Senate File 2356 - Enrolled

Senate File 2356

AN ACT

RELATING TO THE HEALTH CARE INCLUDING IOWACARE PROGRAM PROVISIONS AND THE CREATION OF AN IOWA INSURANCE INFORMATION EXCHANGE TO PROMOTE TRANSPARENCY, QUALITY, SEAMLESSNESS, AND INFORMED CHOICES RELATIVE TO HEALTH CARE COVERAGE.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

DIVISION I

IOWACARE PROGRAM AND OTHER HEALTH CARE OPTIONS

Section 1. Section 249J.7, Code 2009, is amended to read as follows:

249J.7 Expansion population provider network.

1. a. Expansion population members shall only be eligible to receive expansion population services through a provider included in the expansion population provider network. Except as otherwise provided in this chapter, the expansion population provider network shall be limited to a publicly owned acute care teaching hospital located in a county with a population over three hundred fifty thousand, the university of Iowa hospitals and clinics, ~~and the state hospitals for persons with mental illness designated pursuant to section 226.1 with the exception of the programs at such state hospitals for persons with mental illness that provide substance abuse treatment, serve gero-psychiatric patients, or treat sexually violent predators~~ and a regional provider network utilizing the federally qualified health centers or federally qualified health center look-alikes in the state, to provide primary care to members.

b. (1) The department shall develop a plan to phase-in the regional provider network by determining the most highly underserved areas on a statewide and regional basis, and targeting these areas for prioritization in implementing the regional provider network. In developing the phase-in plan the department shall consult with the medical assistance projections and assessment council created in section 249J.20. Any plan developed shall be approved by the council prior to implementation. The phase-in of the regional provider network shall be implemented in a manner that ensures that program expenditures do not exceed budget neutrality limits and funded program capacity, and that ensures compliance with the eligibility maintenance of effort requirements of the federal American Recovery and Reinvestment Act of 2009.

(2) Payment shall only be made to designated participating primary care providers for eligible primary care services provided to a member.

(3) The department shall adopt rules pursuant to chapter 17A, in collaboration with the medical home advisory council created pursuant to section 135.159, specifying requirements for medical homes including certification, with which regional provider network participating providers shall comply, as appropriate.

(4) The department may also designate other private

providers and hospitals to participate in the regional provider network, to provide primary and specialty care, subject to the availability of funds.

(5) Notwithstanding any provision to the contrary, the department shall develop a methodology to reimburse regional provider network participating providers designated under this subsection.

c. Tertiary care shall be provided to eligible expansion population members residing in any county in the state at the university of Iowa hospitals and clinics.

d. Until such time as the publicly owned acute care teaching hospital located in a county with a population over three hundred fifty thousand notifies the department that such hospital has reached service capacity, the hospital and the university of Iowa hospitals and clinics shall remain the only expansion population providers for the residents of such county.

2. Expansion population services provided to expansion population members by ~~providers included in the expansion population provider network~~ the publicly owned acute care teaching hospital located in a county with a population over three hundred fifty thousand and the university of Iowa hospitals and clinics shall be payable at the full benefit recipient rates.

3. Providers included in the expansion population provider network shall submit clean claims within twenty days of the date of provision of an expansion population service to an expansion population member.

4. Unless otherwise prohibited by law, a provider under the expansion population provider network may deny care to an individual who refuses to apply for coverage under the expansion population.

5. Notwithstanding the provision of section 347.16, subsection 2, requiring the provision of free care and treatment to the persons described in that subsection, the publicly owned acute care teaching hospital described in subsection 1 may require any sick or injured person seeking care or treatment at that hospital to be subject to financial participation, including but not limited to copayments or premiums, and may deny nonemergent care or treatment to any person who refuses to be subject to such financial participation.

6. The department shall utilize certified public expenditures at the university of Iowa hospitals and clinics to maximize the availability of state funding to provide necessary access to both local primary and specialty physician care to expansion population members. The resulting savings to the state shall be utilized to reimburse physician services provided to expansion population members at the university of Iowa college of medicine, to reimburse providers designated to participate in the regional provider network for services provided to expansion population members, and for deposit in the nonparticipating provider reimbursement fund created in section 249J.24A to be used in accordance with the purposes and requirements of the fund.

7. The department shall adopt rules to establish clinical transfer protocols to be used by providers included in the expansion population provider network.

Sec. 2. Section 263.18, subsection 4, Code 2009, is amended to read as follows:

4. The physicians and surgeons on the staff of the university of Iowa hospitals and clinics who care for patients provided for in this section may charge for the medical services provided under such rules, regulations, and plans approved by the state board of regents. However, a physician or surgeon who provides treatment or care for an expansion population member pursuant to chapter 249J shall ~~not charge or~~ only receive ~~any~~ compensation for the treatment or care ~~except the salary or compensation fixed by the state board of regents to be paid from the hospital fund~~ provided in accordance with section 249J.7.

Sec. 3. REVIEW OF MEDICAL TRANSPORTATION COSTS FOR IOWACARE. The department of human services shall review the costs of transportation to and from a provider included in the expansion population provider network under the IowaCare program. The department shall report the results of the review to the general assembly by December 15, 2010.

Sec. 4. DIABETES == PLAN FOR COORDINATION OF CARE. The department of public health shall work with all appropriate entities to develop a plan for coordination of care for individuals with diabetes who receive care through community health centers, rural health clinics, free clinics, and other members of the Iowa collaborative safety net provider network established pursuant to section 135.153, as determined by the department. The plan may include provisions to establish a diabetic registry, to provide access to medically necessary drugs through entities such as the Iowa prescription drug corporation, and to collect data as necessary to assist the affected medical providers in tracking and improving the care of their patients with diabetes, while also informing future public policy decision makers regarding improved care for individuals with diabetes, notwithstanding an individual's health care coverage status or choice of health care provider.

Sec. 5. IOWACARE == EXTENSION OF WAIVER. The department of human services shall amend the extension proposal for the IowaCare section 1115 demonstration waiver and shall submit applicable state plan amendments under the medical assistance program to provide expansion population services through the expansion population network pursuant to section 249J.7, as amended by this Act, within the budget neutrality cap and subject to availability of state matching funds.

Sec. 6. IOWACARE POPULATION == OPTIMIZATION OF SERVICE DELIVERY AND OUTCOMES. The publicly owned acute care teaching hospital located in a county with a population over three hundred fifty thousand, the federally qualified health center located in such county, and the university of Iowa hospitals and clinics shall actively collaborate to optimize effective and efficient delivery of services that result in the best possible outcomes for IowaCare members.

DIVISION II

IOWA INSURANCE INFORMATION EXCHANGE

Sec. 7. NEW SECTION. 505.32 Iowa insurance information exchange.

1. Purpose. The purpose of this section is to establish an information clearinghouse where all Iowans can obtain information about health care coverage that is available in this state including availability of care delivered by safety=net providers and comparisons of benefits, premiums, and out=of=pocket costs.

2. Definitions. As used in this section, unless the context

otherwise requires:

a. "Carrier" means an insurer providing accident and sickness insurance under chapter 509, 514, or 514A and includes a health maintenance organization established under chapter 514B if payments received by the health maintenance organization are considered premiums pursuant to section 514B.31 and are taxed under chapter 432. "Carrier" also includes a corporation which becomes a mutual insurer pursuant to section 514.23 and any other person as defined in section 4.1, subsection 20, who is or may become liable for the tax imposed by chapter 432.

b. "Commissioner" means the commissioner of insurance.

c. "Creditable coverage" means the same as defined in section 513B.2.

d. "Exchange" means the Iowa insurance information exchange.

e. "Health insurance" means accident and sickness insurance authorized by chapter 509, 514, or 514A.

f. (1) "Health insurance coverage" means health insurance coverage offered to individuals.

(2) "Health insurance coverage" does not include any of the following:

(a) Coverage for accident=only, or disability income insurance.

(b) Coverage issued as a supplement to liability insurance.

(c) Liability insurance, including general liability insurance and automobile liability insurance.

(d) Workers' compensation or similar insurance.

(e) Automobile medical=payment insurance.

(f) Credit=only insurance.

(g) Coverage for on=site medical clinic care.

(h) Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance coverage or benefits.

(3) "Health insurance coverage" does not include benefits provided under a separate policy as follows:

(a) Limited=scope dental or vision benefits.

(b) Benefits for long=term care, nursing home care, home health care, or community=based care.

(c) Any other similar limited benefits as provided by rule of the commissioner.

(4) "Health insurance coverage" does not include benefits offered as independent noncoordinated benefits as follows:

(a) Coverage only for a specified disease or illness.

(b) A hospital indemnity or other fixed indemnity insurance.

(5) "Health insurance coverage" does not include Medicare supplemental health insurance as defined under section 1882(g)(1) of the federal Social Security Act, coverage supplemental to the coverage provided under 10 U.S.C. ch. 55 and similar supplemental coverage provided to coverage under group health insurance coverage.

g. "Legislative health care coverage commission" or "commission" means the legislative health care coverage commission created in 2009 Iowa Acts, ch. 118, section 1.

h. "Medicare" means the federal government health insurance program established under Tit. XVIII of the federal Social Security Act.

i. "Organized delivery system" means an organized delivery system as licensed by the director of public health.

3. Iowa insurance information exchange established. An Iowa insurance information exchange is established in the insurance division of the department of commerce under the authority of the commissioner of insurance.

a. The commissioner, in collaboration with the legislative health care coverage commission, shall develop a plan of operation for the exchange within one hundred eighty days from the effective date of this section. The plan shall create an information clearinghouse that provides resources where Iowans can obtain information about health care coverage that is available in the state.

b. The commissioner shall keep records of all financial transactions related to the establishment and operation of the exchange and shall deliver an annual fiscal report of the costs of administering the exchange to the general assembly by December 15 of each year.

4. Powers and duties of exchange.

a. The commissioner shall report on the status of the exchange at all regular meetings of the legislative health care coverage commission, including progress in developing and implementing the exchange operationally, resources available through the exchange, information about utilization of the resources offered by the exchange, including demographic information that illustrates how and by whom the exchange is being utilized, and the costs of implementing and operating the exchange. The commissioner may make recommendations to the commission for including but not limited to the following:

(1) Promotion of greater transparency in providing quality data on health care providers and health care coverage plans and in providing data on the cost of medical care that is easily accessible to the public.

(2) Statutory options that improve seamlessness in the health care system in this state.

(3) Funding opportunities to increase health care coverage in the state, particularly for individuals who have been denied access to health insurance coverage.

b. The commissioner shall implement and maintain information on the insurance division internet site that is easily accessible and available to consumers and purchasers of health insurance coverage regarding each carrier licensed to do business in this state. The information provided shall be understandable to consumers and purchasers of health insurance coverage and shall include but is not limited to information regarding plan design, premium rate filings and approvals, health care cost information, and any other information specific to this state that the commissioner determines may be beneficial to consumers and purchasers of health insurance coverage. The commissioner may contract with outside vendors and entities to assist in providing this information on the internet site.

c. The exchange shall provide information about all public and private health care coverage that is available in this state including the cost to the public, and comparisons of benefits, premiums, and out=of=pocket costs.

(1) The commissioner may establish methodologies to provide uniform and consistent side=by=side comparisons of the health care coverage options that are offered by carriers, organized delivery systems, and public programs in this state including but not limited to benefits covered and not covered, the amount of coverage for each service, including copays and deductibles,

administrative costs, and any prior authorization requirements for coverage.

(2) The commissioner may require each carrier, organized delivery system, and public program in this state to describe each health care coverage option offered by that carrier, organized delivery system, or public program in a manner so that the various options can be compared as provided in subparagraph (1).

d. The commissioner shall provide ongoing information to taxpayers about the costs of public health care programs to the state, including the administrative costs of the programs and the percentage and source of state and federal funding for the programs, utilizing information provided by the department of human services and the department of public health.

e. The exchange may provide information to assist Iowans with making an informed choice when selecting health care coverage.

f. The commissioner may utilize independent consultants, as deemed necessary, to assist in carrying out the powers and duties of the exchange.

g. The commissioner may periodically advertise the general availability of health care coverage information available from the exchange.

5. Rules. The commissioner shall adopt rules pursuant to chapter 17A to implement the provisions of this section.

JOHN P. KIBBIE
President of the Senate

PATRICK J. MURPHY
Speaker of the House

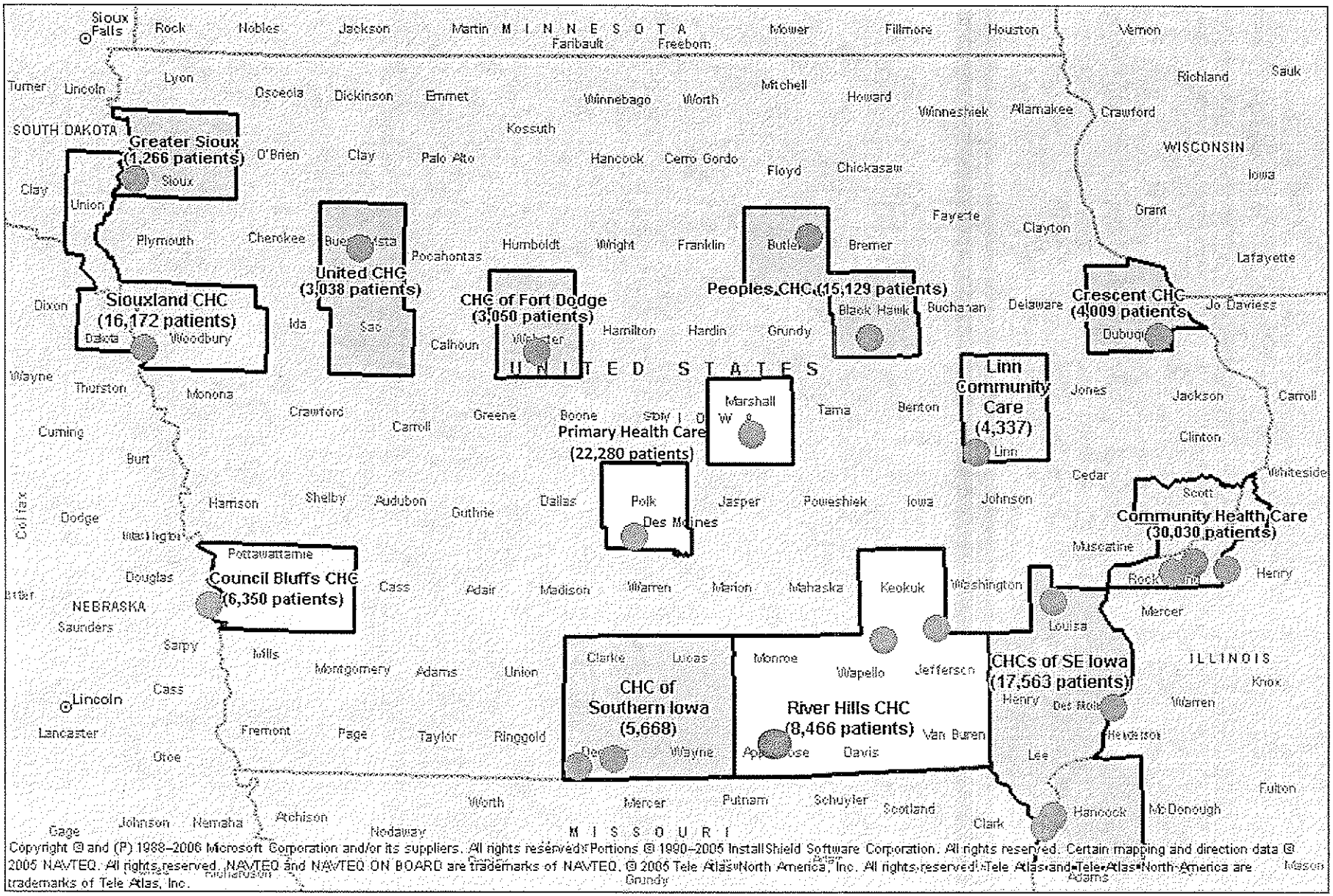
I hereby certify that this bill originated in the Senate and is known as Senate File 2356, Eighty=third General Assembly.

MICHAEL E. MARSHALL
Secretary of the Senate

Approved _____, 2010

CHESTER J. CULVER
Governor

Iowa's Community Health Centers



IowaCare Medical Home Model

I. Background

a. IowaCare is an 1115 demonstration waiver that expanded Medicaid to 200% of the Federal Poverty Level for adults (age 19-64) who don't otherwise qualify for Medicaid. The coverage includes single adults and childless couples. The IowaCare program has a limited benefit package (inpatient/outpatient hospital, physician, limited dental and transportation), and a limited provider network. The provider network has been limited to two providers – Broadlawns Medical Center in Polk County and the University of Iowa Hospitals and Clinics in Iowa City, which provides service statewide.

b. SF2356 as amended and passed by the Senate, expands the provider network under the current IowaCare program to include a regional primary care provider network, beginning with a phased in approach of Federally Qualified Health Centers (FQHC). The bill mandates the FQHC's selected by the Department of Human Services to provide primary health care services to the IowaCare population and to comply with certification requirements of a Medical Home.

II. Establishment of 3-4 Medical home sites beginning with phased in approach;

a. 1-2 FQHC's on western side of state
b. Broadlawns Medical Center
c. University of Iowa Hospitals and Clinics

III. Medical Home Certification

a. Establish Interim minimum standards for IowaCare Medical Home, transitioning to permanent certification process (if there is not an Iowa certification process we are looking at NCQA).

b. Medical Home minimum standards;

1. Access to care and information;

- Accessibility-24 hours/day, physician on call

2. Care Management

- Comprehensive physical exam, and Personal Treatment Plan on annual basis
- Disease Management Program
- Wellness/Disease Prevention Program

3. Health Information Technology (HIT);

- Demonstrate evidence of acquisition, installation and adoption of an electronic health record (EHR) system
- Established plan for meaningful use of health information exchange (HIE) in accordance with the Federal Register requirement
- Registry Function/Immunization Registry

IV. Payment System Methodology

a. A monthly care coordination payment PMPM up front at time of member enrollment in Medical Home. Then a possible performance-based component PMPM at end of each year based on evidenced based quality measures and member outcomes

Level of Certification/Year	Monthly Care Coordination PMPM	Performance Based Reimbursement	Potential total Reimbursement PMPM
Year 1	$3.00	$1.00	$4.00
Year 2 -Level 1	$1.50	$1.50	$3.00
Level 2	$2.50	$1.50	$4.00
Level 3	$3.50	$1.50	$5.00

b. Peer to peer conferencing reimbursement
(UIHC reimbursement for providing specialty care consultation to FQHC's).
   - Reimbursement based on telephone evaluation and management (E/M)codes

c. Possible Federal and State assistance for HIE development, registry expansion, and meaningful use of HIT

V. Performance Reporting and Outcome Measurement

a. At least 75% of the members enrolled in the Medical Home Pilot entered into the registry according to their chronic condition

b. At least 75% of all members enrolled in pilot have had their smoking status documented

c. At least 75% of all members enrolled in the pilot have annual immunizations or there is documentation that immunizations were offered, education provided to member, and member refused
d. At least 75% of all eligible women enrolled have their annual cervical screen
e. At least 75% of all enrolled members with a diagnosis of Diabetes have had at least one HgbA1C annually
f. Each network provider in the pilot has or is in the process of developing a reminder service to inform members of appropriate preventative services
g. Each network provider in the pilot has developed an effective system of sharing clinical information with the UIHC, and will develop an efficient process for referrals to the UIHC for specialty care
h. Documentation of referrals

VI. Provider integration/system of care approach

a. Concentration of care in Medical Home – avoidance of need for specialty visits/hospital care.
b. Development of referral protocols between providers and UIHC
c. Peer to peer consultation between medical home and UIHC specialty providers to avoid need for traveling to UIHC and higher level of care
d. Exploration of telemedicine for specialty care at Medical Home site. Options- G0406-G0408 Telehealth

PPC-PCMH Scoring

Level of Qualifying	Points	Must Pass Elements at 50% Performance Level
Level 3	75 - 100	10 of 10
Level 2	50 – 74	10 of 10
Level 1	25 – 49	5 of 10
Not Recognized	0 – 24	< 5

Levels: If there is a difference in Level achieved between the number of points and "Must Pass", the practice will be awarded the lesser level; for example, if a practice has 65 points but passes only 7 "Must Pass" Elements, the practice will achieve at Level 1.

Practices with a numeric score of 0 to 24 points or less than 5 "Must Pass" Elements are not Recognized.

PPC-PCMH Content and Scoring

Standard 1: Access and Communication	Pts
A. **Has written standards for patient access and patient communication****	4
B. **Uses data to show it meets its standards for patient access and communication****	5
	9

Standard 2: Patient Tracking and Registry Functions	Pts
A. Uses data system for basic patient information (mostly non-clinical data)	2
B. Has clinical data system with clinical data in searchable data fields	3
C. Uses the clinical data system	3
D. **Uses paper or electronic-based charting tools to organize clinical information****	6
E. **Uses data to identify important diagnoses and conditions in practice****	4
F. Generates lists of patients and reminds patients and clinicians of services needed (population management)	3
	21

Standard 3: Care Management	Pts
A. **Adopts and implements evidence-based guidelines for three conditions ****	3
B. Generates reminders about preventive services for clinicians	4
C. Uses non-physician staff to manage patient care	3
D. Conducts care management, including care plans, assessing progress, addressing barriers	5
E. Coordinates care//follow-up for patients who receive care in inpatient and outpatient facilities	5
	20

Standard 4: Patient Self-Management Support	Pts
A. Assesses language preference and other communication barriers	2
B. **Actively supports patient self-management****	4
	6

Standard 5: Electronic Prescribing	Pts
A. Uses electronic system to write prescriptions	3
B. Has electronic prescription writer with safety checks	3
C. Has electronic prescription writer with cost checks	2
	8

Standard 6: Test Tracking	Pts
A. **Tracks tests and identifies abnormal results systematically****	7
B. Uses electronic systems to order and retrieve tests and flag duplicate tests	6
	13

Standard 7: Referral Tracking	PT
A. **Tracks referrals using paper-based or electronic system****	4
	4

Standard 8: Performance Reporting and Improvement	Pts
A. **Measures clinical and/or service performance by physician or across the practice****	3
B. Survey of patients' care experience	3
C. **Reports performance across the practice or by physician ****	3
D. Sets goals and takes action to improve performance	3
E. Produces reports using standardized measures	2
F. Transmits reports with standardized measures electronically to external entities	1
	15

Standard 9: Advanced Electronic Communications	Pts
A. Availability of Interactive Website	1
B. Electronic Patient Identification	2
C. Electronic Care Management Support	1
	4

**Must Pass Elements

4/22/10 KM

Fields of Opportunities

STATE OF IOWA

CHESTER J. CULVER, GOVERNOR
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
CHARLES J. KROGMEIER, DIRECTOR

April 21, 2008

Cynthia Mann
Director
Center for Medicaid, CHIP, and Survey and Certification
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Ms. Mann:

First, I would like to thank you and CMS for the collaborative relationship we have enjoyed over the past months with respect to Iowa's 1115 demonstration extension. Iowa has been working with CMS to extend the current waiver which expires June 30, 2010. We have made excellent progress together. This letter is to alert you to legislation recently enacted by the Iowa General Assembly (Senate File 2356), which seeks to improve the program, and due to which we are now asking to amend the Special Terms and Conditions (STCs) we have been discussing with CMS over the past 9 months.

We have kept our project officer, Juliana Sharp, and our Regional Office staff informed of this legislation throughout the session and have discussed the changes verbally with them. This package provides the detail for the requested changes. The package includes:

- A 'mark up' draft of the most recent STCs that includes the required changes.
- Two attachments that detail the reimbursement methodologies.
- Letters of support from affected organizations.

IowaCare Expansion
As you recall, the IowaCare currently covers adults age 19-64 who are below 200% of the Federal Poverty Level. The program covers inpatient and outpatient hospital and physician services at two network hospitals – Broadlawns Medical Center for residents of Polk County and University of Iowa Hospitals and Clinics statewide.

Senate File 2356 seeks to increase access to local primary care for IowaCare members and to implement a Medical Home model to provide for chronic disease management and improve patient self-management. Specifically, SF 2356:

- Requires Iowa to add Federally Qualified Health Centers (FQHCs) on a phased-in basis to provide primary care services. The phase-in is to begin with centers located in the areas of the state that have had the most limited geographic access to services (the Western side of Iowa).

- Requires Iowa to implement a medical home model for primary care services in the IowaCare program.
- Adds a mechanism for payment to other Iowa hospitals for emergency services to IowaCare members under very limited circumstances.

We have amended the STCs to address these changes.

Public Notice
There has been extensive public discussion of these changes beginning last fall. State law established the Legislative Health Coverage Commission in 2009. The commission consists of members representing insurance industry, state agencies, the public, and State Legislators and was charged with developing strategies to cover uninsured adults and develop an insurance exchange model. As part of the strategy to cover uninsured adults, a workgroup focused on expanding the IowaCare 1115 waiver was formed and met five times over the summer and fall. The Commission and IowaCare workgroup meetings were noticed and open to the public. The Commission's work can be found at the following website:
http://www.legis.state.ia.us/aspx/Committees/Committee.aspx?id=484.

Based on Commission recommendations Senate File 2356 was filed in the 2010 General Assembly. The bill had a very robust public policy discussion including a number of subcommittee meetings, committee meetings, and legislative floor debate (all publicly noticed), as well as newspaper coverage on the bill. In addition, we will file administrative rules prior to July 1, 2010 that will also be publicly noticed.

We have included letters of support from several key stakeholder groups.

Summary of STC changes
This document summarizes the more significant changes requested, by section of the STCs.

Section 1 General Program Requirements:

- **Extend the expiration date of June 30, 2013 to December 31, 2013.** We originally proposed a 3 year extension (July 1, 2010 through June 30, 2013). With the passage of national Health Care Reform, the Medicaid expansion will begin January 1, 2014, creating a six month gap between when the renewal would expire and the start of the Medicaid expansion. We expect to transition the 1115 IowaCare waiver to the new State Plan Medicaid expansion in 2014. To ease the transition and avoid having to do a new extension request, we request to amend our STC request to add this additional 6 months.
- **Provider Taxes.** As discussed from our earliest drafts, Iowa requests the prohibition on provider taxes be removed and replace with a STC that specifies that any provider taxes be in compliance with federal law. All provider taxes from July 1, 2010 forward would be through the regular state plan amendment process. Any new provider taxes would have no relationship whatsoever to the 1115 waiver.

Section 6 Delivery System:

- **Provider Network.** We have broken the provider network provisions out into much more detail to make it clear what services are covered by which providers. This is where we have added the FQHCs and the payments to hospitals for limited emergency services. We have discussed verbally with CMS the need for the State to have flexibility in adding FQHCs or removing them based on funding. We have drafted language that provides this flexibility and appropriate notice to CMS. We have also delineated the limitations on the emergency services. The other changes seek to more clearly specify the provider network coverage.

Section 9 Medicaid Reimbursement and Finance:

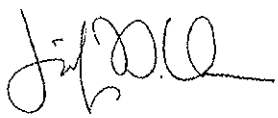
- We have broken this section into more detail to be more clear on reimbursement methods.
- This section also delineates the medical home methodology. We have included a range for the per member per month medical home payment amount because we are still working through those details.

Section 10 Operational Issues:

- We have defined an STC for Goals for the Demonstration project.
- We seek to clearly define the goals and program improvements to be implemented during the Demonstration extension period.
- We have defined goals that align the Medical Home and Health Information Technology activities we have underway.

We are excited about these changes and believe they will be a significant improvement for the program and for Iowans served in the program. We also believe that the Medical Home model we are developing will be able to be deployed in the 'regular' Medicaid State Plan program. Thank you for working with us. We look forward to continuing our dialogue on the program.

Sincerely,



Jennifer H. Vermeer
Iowa Medicaid Director

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00189/7

TITLE: IowaCare Section 1115 Demonstration

AWARDEE: Iowa Department of Human Services

I. PREFACE

The following are the Special Terms and Conditions (STCs) for Iowa's IowaCare section 1115(a) Medicaid Demonstration (hereinafter "Demonstration"). The parties to this agreement are the Iowa Department of Human Services (State) and the Centers for Medicare & Medicaid Services (CMS). This Demonstration was originally approved for the 5-year period, from July 1, 2005, through June 30, 2010. These STCs cover the extension period from July 1, 2010 through December 31, 2013. The STCs set forth below and the lists of expenditure authorities are incorporated in their entirety into the letter approving the Demonstration.

The STCs have been arranged into the following subject areas: General Program Requirements; General Reporting Requirements; Eligibility and Enrollment; Benefits and Coverage; Cost Sharing; Delivery Systems; General Financial Requirements; Monitoring Budget Neutrality; Medicaid Reimbursement and Finance; Operational Issues; and Evaluation.

II. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statues.** The State agrees that it shall comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid Law, Regulation, & Policy.** All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly identified as not applicable in the award letter of which these terms and conditions are part, shall apply to the Demonstration.

3. **Changes in Law**. The State shall, within the time frame specified in law, come into compliance with any changes in Federal law affecting the Medicaid program that occur after the approval date of this Demonstration.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy Statements.** To the extent that a change in Federal law impacts State Medicaid spending on program components included in the Demonstration, CMS shall incorporate

such changes into a modified budget neutrality expenditure cap for the Demonstration. The modified budget neutrality expenditure cap would be effective upon implementation of the change in the Federal law. The growth rates for the budget neutrality baseline are not subject to this STC. If mandated changes in the Federal law require State legislation, the changes shall take effect on the day such State legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

5. **State Plan Amendments.** The State shall be required to submit title XIX State plan amendments to remove reimbursement methodologies affecting any populations covered solely through the Demonstration. However, the State shall not be required to submit title XIX State plan amendments for benefits and eligibility changes to any populations covered solely through the Demonstration. If a population covered through the State plan is affected by a change to the Demonstration, a conforming amendment to the State plan may be required. The State shall not be required to submit title XIX State plan amendments if Congress would enact any health care reform initiatives that change the benefit or eligibility of any of the Demonstration populations covered by this 1115 Waiver.

6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, enrollee rights, delivery systems, cost sharing, evaluation design, Federal financial participation, sources of non-Federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the Demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The State shall not implement changes to these elements without prior approval by CMS. CMS and the State shall develop a comprehensive list within 60 days of the approval of the Demonstration renewal that shall contain all elements of the Demonstration that are subject to the amendment process. Amendments to the Demonstration are not retroactive and FFP will not be available for changes to the Demonstration that have not been approved.

7. **Amendment Process.** Amendment requests must be submitted to CMS for approval no later than 90 days prior to the date of implementation. Amendment requests as specified above shall include the following:

   a) An explanation of the public process used by the State to reach a decision regarding the requested amendment;
   b) A current assessment of the impact the requested amendment shall have on budget neutrality;
   c) An explanation of how the amendment is consistent with the overall principles and objectives of the Demonstration;
   d) A description of how the evaluation design shall be modified to incorporate this amendment request.

8. **Demonstration Phase-Out.** Subject to the Maintenance of Effort requirements in the American Recovery and Reinvestment Act and the Affordable Patient Care Act, the State may suspend or terminate this Demonstration in whole or in part at any time prior to the date of expiration. The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date. In the event the State elects to phase-out the Demonstration, the State shall submit a phase-out plan to CMS at least 6 months prior to initiating phase-out activities. The State may also submit an extension plan on a timely basis to prevent disenrollment of Demonstration enrollees. Nothing herein shall be construed as preventing the State from submitting a phase-out plan with an implementation deadline shorter than 6 months when such action is necessitated by emergent circumstances. The phase-out plan and extension plan are subject to CMS approval. If the project is terminated or any relevant costs not otherwise matchable are suspended by the State, CMS shall be liable for only normal close-out costs.

9. **Enrollment Limitation.** If the State elects to suspend, terminate, or not renew this demonstration as described in paragraph 8, during the last 6 months of the Demonstration, the enrollment of individuals who would not be eligible for Medicaid under the current State plan shall not be permitted unless the Demonstration is extended by CMS.

10. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the Demonstration in whole or in part at any time before the date of expiration, whenever it determines, following a hearing, that the State has materially failed to comply with the terms of the project. CMS shall promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date.

11. **Finding of Non-Compliance.** The State waives none of its rights to challenge CMS' finding that the State materially failed to comply. CMS reserves the right to withdraw expenditure authorities at any time it determines that continuing the expenditure authorities would no longer be in the public interest. If an expenditure authority is withdrawn, CMS shall be liable for only normal close-out costs.

12. **Adequacy of Infrastructure.** The State shall insure the availability of adequate resources for implementation and monitoring of the Demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing; and reporting on financial and other Demonstration components.

13. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The State must continue to comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) and the tribal consultation requirements pursuant to section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009, when any program changes to the Demonstration, including, but not limited to, those referenced in section II, paragraph 6 and section IX, are proposed by the State. In States with Federally recognized Indian tribes, Indiana health programs, and/or Urban Indian organizations, the State is required to submit

evidence to CMS regarding the solicitation of advice from these entities prior to submission of any demonstration proposal, amendment and/or renewal of this Demonstration.

14. **Federal Funds Participation.** No Federal matching for expenditures for this Demonstration will take effect until the implementation date.

III. GENERAL REPORTING REQUIREMENTS

15. **Monthly Calls.** CMS shall schedule monthly conference calls with the State. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the Demonstration. Areas to be addressed include, but are not limited to, health care delivery, enrollment, quality of care, access, the benefit package, cost-sharing, audits, lawsuits, financial reporting and budget neutrality issues, progress on evaluations, State legislative developments, and any Demonstration amendments, concept papers, or State plan amendments the State is considering submitting. CMS shall update the State on any amendments or concept papers under review as well as Federal policies and issues that may affect any aspect of the Demonstration. The State and CMS (both the Project Officer and the Regional Office) shall jointly develop the agenda for the calls.

16. **Quarterly Reports.** The State shall submit progress reports within 60 days following the end of each quarter. The intent of these reports is to present the State's analysis and the status of the various operational areas. These quarterly reports shall include:

    a) A discussion of events occurring during the quarter, or anticipated to occur in the near future, that affect health care delivery, enrollment, quality of care, access, the benefit package, and other operational issues.
    b) Action plans for addressing any policy and administrative issues identified.
    c) Enrollment data, including the number of persons in each Demonstration Population served under the waiver.
    d) Budget neutrality monitoring tables.
    e) Progress on the IowaCare implementation plan.
    f) Other items as requested.

17. **Annual Report.** The State shall submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, utilization data, and policy and administrative difficulties in the operation of the Demonstration. The State shall submit the draft annual report no later than 120 days after the end of each operational year. Within 30 days of receipt of comments from CMS, a final annual report shall be submitted.

18. **Provider Taxes.** All provider taxes operated by the State shall comport with Federal law.

19. **Annual Program Compliance Evaluation.** The State shall submit an annual

evaluation documenting Iowa medical assistance program compliance with each of the following:

- That providers retain 100 percent of the total computable payment of expenditures claimed under title XIX of the Act.

IV. ELIGIBILITY, ENROLLMENT AND BENEFITS

20. **Demonstration Populations.** The following populations are included in the Demonstration:

a) **Demonstration Population 1 (Expansion Population)** includes the following:

i) Individuals ages 19 through 64 with family incomes between 0 and 200 percent of the Federal Poverty Level (FPL) who do not meet eligibility requirements of the Medicaid State plan or other waivers except the Family Planning waiver under title XIX; and

ii) Parents whose incomes between 0 and 200 percent of the FPL are considered in determining the eligibility of a child found eligible under either title XIX or title XXI, and who are not otherwise Medicaid eligible.

b) **Demonstration Population 2 (Spend-Down Pregnant Women)** includes newborns and pregnant women with income at or below 300 percent of the FPL who have incurred medical expenses for all family members that reduce available family income to 200 percent of the FPL.

The eligibility groups are also described in the chart below.

Population Name	Federal Poverty Level (FPL) or other criteria	Expenditure and Eligibility Group Reporting
Population 1: Expansion Population • Individuals ages 19 through 64 • Parents of children found eligible under title XIX or title XXI	0 through 200% of FPL	Expansion Pop.
Population 2: Spend-down Pregnant Women (and newborns)	Less than or equal to 300% of the FPL who have incurred medical expenses that reduce available family income to 200% of the FPL	Spnd-dwn Preg. Wmn.

21. **Enrollment Cap.** Subject to the Maintenance of Effort requirements in the American Recovery and Reinvestment Act and the Affordable Patient Care Act, the State reserves the right to limit Demonstration Populations 1 and 2 to those who are first to apply.

However, any limitation for these populations must be submitted to CMS for review and approval following the process outlined in STC #6.

22. **Benefits and Coverage for Demonstration Populations 1 and 2.** The benefits and coverage for these populations shall be limited to inpatient hospital, outpatient hospital, physician, advanced registered nurse practitioner, dental, pharmacy, medical equipment and supplies, and transportation services, to the extent that these services are covered by the Medicaid State plan. All conditions of service provision will apply in the same manner as under the Medicaid State plan, including, but not limited to, prior authorization requirements and exclusions for cosmetic procedures or those otherwise determined not to be medically necessary.

V. COST SHARING

23. Premiums may be charged to individuals in Demonstration Populations 1 and 2 as follows:

Population	Premiums
• Individuals ages 19 through 64 with family incomes between 0 and 100 percent of FPL who do not meet eligibility requirements of the Medicaid State Plan or other waivers except the Family Planning waiver under title XIX; • Parents whose incomes between 0 and 100 percent of FPL is considered in determining the eligibility of a child found eligible under either title XIX or title XXI, and who are not otherwise Medicaid eligible.	No premium
• Individuals ages 19 through 64 with family incomes are greater than 100 and 200 percent of FPL who do not meet eligibility requirements of the Medicaid State Plan or other waivers except the Family Planning waiver under title XIX; • Parents whose incomes are greater than100 and 200 percent of FPL is considered in determining the eligibility of a child found eligible under either title XIX or title XXI, and who are not otherwise Medicaid eligible. • Individuals assessed a premium shall have the ability to file a hardship exemption if they are unable to pay due to their financial circumstances. The hardship exemption due date is the same as the premium due date, and may not be accepted retroactively.	No more than one-twelfth of 5 percent of the individual's annual family income

VI. DELIVERY SYSTEMS

24. **Primary Provider Network.** The primary provider network is as follows:

Population Name	Provider	Covered Services
Demonstration Population 1	Broadlawns Medical Center	Inpatient Hospital

and 2		Outpatient Hospital Physician, Advanced Registered Nurse Practitioner
	University of Iowa Hospitals and Clinics	Inpatient Hospital Outpatient Hospital Physician, Advanced Registered Nurse Practitioner
	Federally Qualified Health Centers (see STC #25)	Physician, Advanced Registered Nurse Practitioner

25. The State may phase in the addition of Federally Qualified Health Centers in the provider network, based on the availability of funds, beginning with at least one FQHC in the most underserved area of the state by October 1, 2010. The State shall issue public notice and shall notify CMS 30 days prior to adding or removing FQHCs from the provider network. The notification shall include the rationale for the change.

26. **Covered Services Outside the Primary Provider Network.** Services are covered through the primary provider network described above, except for the following providers and services:

Population Name	Provider	Covered Services
Demonstration Population 1 and 2	Any Medicaid-certified Physicians and Advanced Registered Nurse Practitioners, Physician Assistance	Annual comprehensive physical medical examination and laboratory tests as designated by the State. Follow-up care must be obtained from the primary IowaCare provider network
Demonstration Population 1	Medicaid-certified Hospitals located in Iowa, excluding Government-operated Acute Care Teaching Hospitals and University of Iowa Hospitals and Clinics (see STC #27)	Inpatient Hospital Outpatient Hospital Physician Subject to the limitations in STC #27

27. The State may provide limited reimbursement to a hospital who is not a network provider under the following circumstances:

    a) The services are emergency services and it is not medically possible to postpone

provision of services and transfer the individual to a primary network provider, **OR**

b) The beneficiary may not be transferred to a primary network provider due to a lack of inpatient capacity.
c) The beneficiary shall be enrolled in Demonstration Population 1 at the time treatment is provided in order for the services to be covered.
d) The hospital is located in Iowa.
e) **If a or b is met, and c and d is met**, the hospital may be reimbursed for covered services according to the reimbursement policies applicable under the State Plan, subject to the availability of funds.
f) The covered services shall include emergency services, as designated by the State, and medically necessary treatment up to the point the beneficiary is medically stable and may be transferred to a primary network provider.
g) Covered services are limited to services covered for primary network providers.
h) By October 1, 2010, the State shall develop a protocol for hospitals to follow in order to receive payment.

28. **Obstetric and Newborn Services.** The provider network for Obstetric and Newborn Services for Demonstration Population 2 only is as follows:

Population Name	Provider	Covered Services
Demonstration Population 2, **except** beneficiaries who reside in Cedar, Clinton, Iowa, Johnson, Keokuk, Louisa, Muscatine, Scott, or Washington counties	Any Medicaid-certified physician or Advanced Registered Nurse Practitioner	Obstetric and Newborn Services provided in an Inpatient Hospital Outpatient Hospital or physician office Physician
Demonstration Population 2 beneficiaries who reside in Cedar, Clinton, Iowa, Johnson, Keokuk, Louisa, Muscatine, Scott, or Washington counties.	University of Iowa Hospitals and Clinics	Obstetric and Newborn Services provided in an Inpatient Hospital Outpatient Hospital or Physician office

VII. GENERAL FINANCIAL REQUIREMENTS

29. The State shall provide quarterly expenditure reports using the form CMS-64 to report total expenditures for services provided under the Medicaid program, including those provided through the Demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the Demonstration

period. CMS shall provide Federal Financial Participation (FFP) for allowable Demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Attachment B (Monitoring Budget Neutrality for the Demonstration).

30. The following describes the reporting of expenditures subject to the budget neutrality cap:

a) In order to track expenditures under this Demonstration, Iowa shall report Demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual. All expenditures subject to the budget neutrality cap shall be reported on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the Demonstration project number assigned by CMS (including the project number extension, which indicates the Demonstration year in which services were rendered). Corrections for any incorrectly reported Demonstration expenditures for previous Demonstration years must be input within three months of the beginning of the Demonstration. For monitoring purposes, cost settlements must be recorded on Line 10.b, in lieu of Lines 9 or 10.C. For any other cost settlements (i.e., those not attributable to this Demonstration), the adjustments should be reported on lines 9 or 10.C, as instructed in the State Medicaid Manual. The term, "expenditures subject to the budget neutrality cap," is defined below in item 2c.

b) For each Demonstration year, Forms CMS-64.9 Waiver and/or 64.9P Waiver shall be submitted reporting expenditures subject to the budget neutrality cap. The State must complete separate forms for each Demonstration Population: 1) Expansion Population and 2) Spend-down Pregnant Women, The sum of the quarterly expenditures for the two population categories for all Demonstration years shall represent the expenditures subject to the budget neutrality cap (as defined in item 2.c.).

c) For purposes of this section, the term "expenditures subject to the budget neutrality cap" shall include all expenditures on behalf of the individuals included in the Demonstration Populations (as described in item 3 of this section), All expenditures that are subject to the budget neutrality cap are considered

Demonstration expenditures and shall be reported on Forms CMS-64.9Waiver and/or 64.9P Waiver.

d) Premiums and other applicable cost sharing contributions from enrollees collected by the State from enrollees in Demonstration Populations 1 and 2 shall be reported to CMS on Form CMS-64 Summary Sheet line 9.D, columns A and B. In order to assure that the Demonstration is properly credited with premium collections, the IowaCare premium collection should be separated from other collections in the Iowa Medicaid program and reported in the memo portion of the CMS report as well as

reported on line 9.D of the CMS-64 Summary Sheet.

e) Administrative costs shall not be included in the budget neutrality limit, but the State must separately track and report additional administrative costs that are directly attributable to the Demonstration. All administrative costs shall be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver.

f) All claims for expenditures subject to the budget neutrality cap (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the Demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the Demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 Demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

31. For the purposes of this Demonstration, the term "Demonstration eligibles" refers to the following three categories of enrollees:

a) **Expansion Population.** (Demonstration Population 1)
   (i) Individuals ages 19 through 64 with family incomes between 0 and 200 percent of the FPL who do not meet eligibility requirements of the Medicaid State plan or other waivers except the Family Planning waiver under title XIX; and
   (ii) Parents whose incomes between 0 and 200 percent of the FPL are considered in determining the eligibility of a child found eligible under either title XIX or title XXI, and who are not otherwise Medicaid eligible.

b) **Spend-down Pregnant Women.** (Demonstration Population 2) Newborns and pregnant women with income at or below 300 percent of the FPL who have incurred medical expenses of all family members that reduce available family income to 200 percent of the FPL.

32. The standard Medicaid funding process shall be used during the Demonstration. Iowa must estimate matchable Medicaid expenditures on the quarterly Form CMS-37. In addition, the estimate of matchable Demonstration expenditures (total computable and Federal share) subject to the budget neutrality cap must be separately reported by quarter for each Federal fiscal year (FFY) on the Form CMS-37.12 for both the Medical Assistance Program and Administrative Costs. CMS shall make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of

the grant award to the State.

33. Subject to CMS approval of the source(s) of the non-Federal share of funding, CMS shall provide FFP at the applicable Federal matching rates for the following, subject to the limits described in Attachment B:

    a) Administrative costs, including those associated with the administration of the Demonstration;
    b) Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved State plan;
    c) Net medical assistance expenditures made with dates of service during the operation of the Demonstration.

34. The State shall certify State/local monies used as matching funds for the Demonstration and shall further certify that such funds shall not be used as matching funds for any other Federal grant or contract, except as permitted by law. All sources of the non-Federal share of funding and distribution of monies involving Federal match are subject to CMS approval. Upon review of the sources of the non-Federal share of funding and distribution methodologies of funds under the Demonstration, all funding sources and distribution methodologies deemed unacceptable by CMS shall be addressed within the time frames set by CMS. Any amendments that impact the financial status of the program shall require the State to provide information to CMS regarding all sources of the non-Federal share of funding.

35. The State shall submit its Medicaid Statistical Information System (MSIS) data electronically to CMS in accordance with CMS requirements and timeliness standards. The State shall ensure, within 120 days of the approval of the Demonstration, that all prior reports are accurate and timely.

VIII. MONITORING BUDGET NEUTRALITY

36. Iowa shall be subject to a cap on the amount of Federal title XIX funding that the State may receive on selected Medicaid expenditures during the demonstration period.

37. Budget neutrality is determined on an aggregate cap basis as follows:

    a) For each year of the budget neutrality agreement an annual cap is calculated for the entire Demonstration.

    b) Years - 6-8 of the demonstration period have an annual cap determined by applying a trend rate of 7 percent to the previous year's cap.

    c) The cumulative budget neutrality cap for the Demonstration is the sum of the annual caps for the demonstration period:

Demonstration Year	Annual Budget Neutrality Cap
SFY 2011	**$143.0 million**
SFY 2012	$153.4 million
SFY 2013	$164.2 million
Cumulative Total	**$460 million**

38. The Federal share of this limit shall represent the maximum amount of FFP that the State may receive during the approved demonstration period for the IowaCare program. For each DY, the Federal share shall be calculated using the Federal medical assistance percentage rate(s) applicable to that year.

39. CMS shall enforce budget neutrality over the life of the Demonstration rather than on an annual basis. However, if the State exceeds the calculated cumulative target limit by the percentage identified below for any of the Demonstration years, the State shall submit a corrective action plan to CMS for approval.

Year	Cumulative Target (Total Computable Funds)	Cumulative Target Definition	Percentage
SFY2011	$731.2 million	Years 1 through 6 combined budget neutrality caps plus	0 percent
SFY2012	$884.6 million	Years 1 through 7 combined budget neutrality caps plus	0 percent
SFY2013	$1.0 billion	Years 1 through 8 combined budget neutrality caps plus	0 percent

The State shall subsequently implement the approved corrective action plan.

40. If at the end of this Demonstration period the budget neutrality limit has been exceeded, the State assures CMS that the excess Federal funds shall be returned to CMS. If the Demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test shall be based on the time elapsed through the termination date.

41. After December 31, 2005, no duplication of coverage of the Part D benefits shall be provided under this Demonstration.

IX. MEDICAID REIMBURSEMENT AND FINANCE

42. Payments to providers for covered services will be based on claims submitted. The payment will be made following guidelines of the regular Medicaid process. Claims will be priced according to the approved Medicaid reimbursement methodology under

the State Plan in effect on December 1, 2009 with the following exceptions and detailed in Attachment 2:

a) Payment rates for the government-owned acute care teaching hospital and the University of Iowa Hospitals and Clinics shall be at the rates in effect on November 30, 2009.
b) Payment rates for FQHCs shall be according to the Medicaid physician fee schedule in the Medicaid State Plan.

43. Non-Participating Hospital. Beginning October 1, 2010, the state may provide- limited reimbursement to a hospital who is not a network provider for providing services in an emergency situation in accordance with STC #27. Payment rates for Medicaid-certified hospitals located in Iowa excluding a government operated acute teaching hospital and the University of Iowa shall be at the rates in effect on June 30, 2010.

43. **Medical Home.** By October 1, 2010, the State shall establish a medical home model within the primary provider network, including medical home certification requirements, payment methods, provider performance measurement, and evaluation within the Demonstration evaluation design. The State may require Demonstration 1 beneficiaries who reside in counties within the service region of the medical home to utilize the medical home prior to accessing specialty or hospital services through other network providers. The State shall establish a per member per month payment of between $2 and $6 for certified medical homes in the demonstration.

44. The State shall also submit a SPA effective July1, 2010, to eliminate the Enhanced DSH payments that were provided under the 1115 Waiver. All DSH payments to any qualifying hospital in the State of Iowa shall be paid through an approved state plan methodology and not as part of this 1115 waiver for Demonstration Years 6 through 8.

45. The State shall implement changes to its Medicaid Management Information System (MMIS) to pay claims submitted by hospitals in the provider network, serving IowaCare members.

46. All future SPAs that will affect any of the Demonstration Populations must be submitted to CMS 30 days prior to execution. Any Amendment submitted after this date shall subject the State to deferred FFP for Demonstration Population and service expenditures.

X. OPERATIONAL ISSUES

47. Pursuant to Section II, paragraph 6, changes related to eligibility, enrollment, enrollee

rights, benefits, delivery systems, cost sharing, evaluation design, sources of non-Federal share of funding, FFP, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the Demonstration, following the process set forth in section II, paragraph 7. The State shall not implement changes to these elements without prior approval by CMS. CMS and the State shall develop a comprehensive list that shall contain all elements of the Demonstration that are subject to the amendment process within 60 days of the approval of the Demonstration.

48. **Goals for the Demonstration.** The goals and performance benchmarks for the Demonstration are as follows:

a) Increase local access to primary and preventative care for Demonstration Population 1 by expanding the provider network to include Federally Qualified Health Centers. By October 1, 2010, add at least one FQHC in the most underserved region of the state. By December 1, 2010 submit a plan to CMS to phase-in additional FQHCs.
b) Decrease hospital uncompensated care and medical debt burdens for Demonstration Population 1 by adding limited payment to non-network hospitals for emergency treatment when the member is not able to access a network provider. By October 1, 2010 establish the requirements and protocols for payment to non-network hospitals.
c) By October 1, 2010 establish a medical home model within the primary provider network, including medical home certification requirements, payment methods, provider performance measurement, and evaluation within the Demonstration evaluation design. The specific goals of the medical home model are the following:
    i. Establish three medical home sites in Demonstration Year 6 and by December 1, 2010, develop a plan for expanding the number of medical home sites through the Demonstration period.
    ii. By October 1, 2010, establish minimum requirements for a medical home.
    iii. Collaborate by participating in quarterly meetings with the Iowa Medical Home Advisory Committee in developing the medical home model.
    iv. Improve health care outcomes for members with chronic disease through medical home care coordination and use of disease registries.
    v. Decrease utilization of high cost and geographically difficult to access specialty and hospital care through medical home care management.
    vi. Add payment for peer consultation for medical home/specialty consultation to reduce the need for travel to the University of Iowa Hospitals and Clinics for specialty care.
    vii. Increase beneficiary self-management skills and primary care engagement.
    viii. Implement at least one disease management program within each medical home.
    ix. By October 1, 2010, establish a payment methodology for medical home.
    x. By October 1, 2010, establish performance measurements for medical homes.
    xi. By July 1, 2011, develop a plan for expanding the medical home model in the full-benefit Medicaid program.
    xii. Include information on the above elements in the required quarterly and annual reports to CMS.
d) Increase the adoption and meaningful use of Electronic Health Records and Health

Information Exchange by primary network providers in the Demonstration.

i. By July 1, 2010, all primary network providers will either have an Electronic Health Record, or will have a plan and timeframe for adopting an Electronic Health Record.
ii. As a minimum requirement for all medical homes, the medical home site shall have a disease registry in operation that it used to manage at least one chronic disease.
iii. The State shall collaborate with the State's Health Information Exchange designated entity to ensure that primary network providers are a high priority for connecting to the State's Health Information Exchange.
iv. The State may facilitate the exchange of electronic information, as a transition to the statewide Health Information Exchange, among network providers if feasible.
v. By Year 7 of the Demonstration, network providers will be achieving meaningful use and are connected to and utilizing the statewide HIE.

e) By January 1, 2011, develop a quality assurance plan for the Demonstration. The State will collaborate with CMS to select adult quality measures, means and frequency of data/measure collection, and how the quality measures will be used for program improvement.
f) The State shall continue to provide coverage of smoking cessation drugs and counseling programs and shall monitor usage and success of the programs in reducing smoking among recipients of medical assistance and expansion population members.
g) The department of human services shall review the costs of transportation to and from a provider included in the expansion population provider network under the IowaCare program. The department shall report the results of the review to the general assembly by December 15, 2010.

49. The State shall submit to CMS any plans for implementing continuum of care mechanisms for this Demonstration including marketing, enrollee education, and provider education prior to implementation.

50. The State shall submit the operations protocols for the Account for Health Care Transformation and the IowaCare account.

XI. EVALUATION

51. **Submission of Draft Evaluation Design.** The State shall submit to CMS for approval within 120 days from the award of the Demonstration a draft evaluation design. At a minimum, the draft design shall include a discussion of the goals, objectives, and specific hypotheses that are being tested, including those that focus specifically on the target populations for the Demonstration. The draft design shall discuss the outcome measures that shall be used in evaluating the impact of the Demonstration during the period of approval, particularly among the target population. It shall discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the Demonstration shall be isolated from other initiatives occurring in the State. The draft design shall identify whether the State shall conduct the evaluation, or select an outside contractor for the evaluation.

52. **Final Evaluation Design and Implementation.** CMS shall provide comments on the draft design within 60 days of receipt, and the State shall submit a final design within 60 days of receipt of CMS' comments. The State shall implement the evaluation design, and submit to CMS a draft of the evaluation report 120 days prior to the expiration of the Demonstration. CMS shall provide comments within 60 days of receipt of the report. The State shall submit the final report prior to the expiration date of the Demonstration.

53. **Cooperation with Federal Evaluators.** Should CMS undertake an evaluation of the Demonstration, the State must fully cooperate with Federal evaluators and their contractors' efforts to conduct an independent, federally funded evaluation of the Demonstration.

Health Care Reform

To Do List

List of all the items that will need a full analysis of the bill, identification of questions, analysis of implementing federal regulations and guidance as it is issued, decisions on what to do, IT and operations analysis, new policy, operations and system design, implementation plans.

Eligibility

- "Eligibility Gateway" – system for residents to apply for enrollment and receive eligibility determination in health subsidy, Medicaid or CHIP programs.
- Coordination of enrollment between Medicaid and exchanges through state-run websites. DHS and Exchange coordinate enrollment procedures to provide seamless enrollment for all programs.
- Single eligibility form.
- Potentially determine eligibility for tax credit programs.
- CHIP – evaluate need for tax credits if we exceed allotment
- Develop eligibility policy for Medicaid Expansion to 133% FPL (with 5% income disregard)
- Evaluate option to expand early
- Develop reports on changes in enrollment for CMS (RE newly eligible)
- Analyze Maintenance of Effort requirements in light of changing income standards
- Analyze the modified gross income standard and its applicability/impact to all eligibility groups, and how the MOE requirement affects them.
- Extension of foster care to age 25
- Evaluate State Plan option for Family Planning Waiver prior to the time we need to start the waiver extension process.
- Understand impacts of changes for legal immigrants
- CHIP – children of public employees eligible for CHIP
- Allow hospitals to do presumptive eligibility determination for ALL Medicaid programs
- Determine the extent to which the 'exchange' determines eligibility
- Requirement to apply spousal impoverishment
- No cost sharing in HCBS

Benefit Package/System Capacity

- Develop a new benchmark benefit package for nonpregnant adults (newly eligible).
- Transition of IowaCare members

- Medicaid provider capacity
- IME impacts due to increases in population/volume
- Medicaid system ability to manage cost of health care utilization of new enrollees, provide health literacy information, manage care.
- Evaluate and take advantage of opportunities/impacts for mental health system due to new coverage
- Evaluate impacts to CHIP
- No payments for health care acquired conditions – what are they, how will we implement
- States must contract with one or more Medicare Recovery Audit Contractor
- Submit data elements from MMIS needed for program integrity, program oversight and administration
- New requirements on termination of providers
- Registration of clearing houses
- New provider disclosure requirements

Financing

- Evaluate fiscal impacts of the eligibility changes
- Are IowaCare members 'newly eligibile' and eligible for 100% federal match?
- Woodwork effects
- Fiscal impact of converting IowaCare to new program
- Determine impact of Disproportionate Share Hospitals changes and impact to IowaCare
- IowaCare timing gap (ends June 30, 2013, new program starts January 1, 2014)
- Drug rebate changes – need more info from CMS – analyze fiscal impact ID options to replace lost savings
- Drugs – UPL change – amend IME processes
- Medicaid payment rates for primary care increase to 100% of Medicare for primary care services
- 60 day overpayment rule change – amend IME processes
- Cost impact for implementation (field, IME, etc)
- Required coverage for tobacco cessation
- Required coverage for free-standing birthing centers
- Children/hospice policy change
- New health care quality measures
- Increase in FMAP to rebalance NF and HCBS

Opportunities to be evaluated:

- Bundled payment demonstration in up to 8 states

- Global capitated payment demonstration for safety net hospitals
- Adds payment reform models to list of projects for Center for Innovation including rural telehealth expansions and development of rapid learning network
- 3 year demonstration project on IMD reimbursement for adults in need of medical assistance to stabilize an emergency psychiatric condition.
- Funding to develop and implement one or more evidence-based maternal infant and early childhood visitation models.
- Grant program for operation of school based health clinics in medically underserved areas (begins 2010)
- Demonstration project to allow pediatric medical providers who meet certain criteria to be accountable care organizations. Allow participating providers to share in federal and state cost savings achieved for Medicaid and CHIP. S
- Preventive services – 1% increase in FMAP
- Grants to states to collection d report health care quality data for Medicaid adults.
- New state plan option for beneficiaries with chronic conditions to designate a health home. Medicaid enrollees with at least one serious and persistent mental health condition qualify to receive services under the option.
- Incentives for enrollees for healthy lifestyles, etc
- $75M for 8 demo states to expand the number of emergency inpatient psychiatric care beds.
- State Plan option for community based attendant supports for persons with disabilities and meet institutional level of care, includes 6% increase in FMAP
-

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National Association of State Medicaid Directors

an affiliate of the American Public Human Services Association

Summary of Provisions Affecting Medicaid and SCHIP in the Patient Protection and Affordable Care Act (P.L. 111-148) as Amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152)

April 23, 2010 Draft

TITLE I— QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS

Subtitle E—Affordable Coverage Choices for All Americans

Section 1413 – Streamlining of Procedures for Enrollment Through an Exchange and State Medicaid, CHIP, and Health Subsidy Programs

Directs HHS to establish a system where individuals can apply for Medicaid, CHIP, tax credits for individual coverage through the exchange, or a State Basic Health Program for Residents Ineligble for Medicaid (created under the authority of Section 1331). The system must ensure that if individuals who are eligible for Medicaid or CHIP apply for tax credits in the exchange, they are enrolled Medicaid/CHIP instead.

TITLE II—ROLE OF PUBLIC PROGRAMS

Subtitle A—Improved Access to Medicaid

Section 2001 – Medicaid Coverage for the Lowest Income Populations

Eligibility

Creates a mandatory eligibility group that expands Medicaid to 133% of Federal Poverty Level (FPL) for all individuals, without regard to categorical eligibility, effective January 1, 2014. Excludes people who are eligible for Medicaid through another mandatory eligibility group, who are entitled to Medicare Part A (regardless of whether they are enrolled) or who are enrolled in Medicare Part B. *Sec. 1004 of the Reconciliation Bill amends this group to include an income disregard based on the dollar amount of 5% of the 133% FPL level.*

The Bill also increases the mandatory income eligibility level for children age 6-19 to 133% FPL; these individuals are funded with the State's regular FMAP.

Allows states the option to expand coverage to the 133% FPL group earlier, beginning April 1, 2010 (*as amended by Section 10201*). States that expand prior to 2014 have the option to phase-in coverage, provided that individuals with higher incomes are not covered prior to individuals with lower incomes and that parents do not receive coverage unless their children are covered. Prior to 2014, states would receive their normal FMAP for individuals covered through the 133% group. Additionally, because this is an "expanded group," states would not receive the higher FMAP from the American Recovery and Reinvestment Act for this population.

Additionally, States have the option to expand coverage above 133% of FPL up to the highest income eligibility level in the State's Medicaid program (either through the State plan or a waiver). If a state chooses to expand beyond 133% FPL, it can phase-in coverage based on either income level or categorical groups. However, the state must provide coverage to individuals with lower income before it expands coverage to individuals with higher income within the same category.

States that allow presumptive eligibility under Section 1920 or 1920A may provide presumptive eligibility for the 133% group or for individuals eligible through Section 1931.

Services

The service package for the 133% group is the Benchmark Benefits Packages, created by the DRA, as defined by Section 1937 of the Social Security Act. States would not receive funding for services provided beyond those included in the Benchmark Benefits Package. Some individuals who enroll in the 133% group are excluded from the Benchmark Packages, such as individuals with disabilities, and would receive full Medicaid Benefits. On January 1, 2014, Benchmark plans are expanded to include the essential health benefits package defined in Section 1302 of the Act, and are required to have mental health parity. The "essential health benefits package" will be defined by HHS, but it must include at least:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance use disorder services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management; and
- Pediatric services, including oral and vision care.

Section 2303 of the act also requires Benchmark plans to offer family planning services, effective upon bill enactment.

Funding

Provides increased Federal Medical Assistance Percentage (FMAP) to cover the costs of the newly eligible individuals. *Sec. 1201 of the reconciliation bill (H.R. 4872) modifies the FMAP provisions to the final policies described in this document.* States will receive the following FMAP for "newly eligible individuals" (defined as individuals older than 19 who are not eligible for Medicaid through the state plan or a waiver on the date of the bill's enactment):

Calendar Year	FMAP for Newly Eligibles
2014	100%
2015	100%
2016	100%
2017	95%
2018	94%
2019	93%
2020 and beyond	90%

Defines expansion states as states with existing coverage for parents and non-pregnant childless adults with incomes up to at least 100% FPL that provides more benefits than premium assistance, hospital-only benefits, a high deductible plan, or health opportunity accounts. The bill gradually reduces expansion states' share of costs for individuals described in the 133% group that the state covered prior to the act. The formula for the reduction in state share is based upon the calendar year FMAP for newly Eligibles, and the "Transition Percentage" for that year. The formula is:

New FMAP = (State's Base FMAP) + [(Transition Percentage) x (FMAP for Newly Eligibles – State's Base FMAP)]

The Transition Percentage for each year is:

Calendar Year	Transition Percentage
2014	50%
2015	60%
2016	70%
2017	80%
2018	90%
2019 and beyond	100%

As an example, the 2015 FMAP for individuals in an expansion state with 54% FMAP that enroll in the 133% group would become:

New FMAP = (State's Base FMAP) + ((Transition Percentage) x (FMAP for Newly Eligibles – State's Base FMAP))
New FMAP = (54) + ((.60) x (100 - 54))
New FMAP = 81.6%

Maintenance of Effort
States are not permitted to have eligibility standards, methodologies, or procedures under the Medicaid State plan or through any waiver that are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under the plan or waiver in effect on the date of enactment. The maintenance of eligibility lasts until the establishment of the exchanges for adults, or until October 1, 2019 for children. Between January 1, 2011 and December 31, 2013, states that have expanded coverage to non-pregnant, non-disabled adults above 133% FPL can reduce the FPL to 133% if they certify that the state is experiencing a budget deficit. States can also transition individuals from waivers to the state plan, or can expand coverage, during the period when the "maintenance of eligibility" is in effect.

Annual Report
States are required to submit annual reports on Medicaid enrollment, broken out by different eligibility categories and populations. States must also identify newly enrolled individuals, and a description of outreach activities. The Secretary may also require additional reporting to monitor enrollment and retention.

Section 2002 – Income Eligibility for Nonelderly Determined Using Modified Gross Income (As Modified by Sec. 1004 of the Reconciliation Act)

Beginning January 1, 2014, the bill requires State Medicaid agencies to use "Modified Adjusted Gross Income" to determine eligibility for most Medicaid beneficiaries. MAGI is defined as "adjusted gross income increased by any amount excluded from gross income under section 911, and any amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax." States will be prohibited from applying income disregards when determining eligibility, premiums or cost-sharing (except for the income disregard included in Sec. 1004 of the Reconciliation bill). The MAGI will also be used to determine premium and cost-sharing requirements. Requires states to establish an "equivalent income test" to make sure that no individuals lose eligibility due to the transition to MAGI and allows HHS to waive provisions of Title 19 (Medicaid) and 21 (CHIP) of the Social Security Act in order to implement the equivalent income test. If an individual does lose eligibility due to the elimination of disregards or the transition to MAGI, the person is grandfathered into Medicaid until the later of March 31, 2014 or the next regularly scheduled eligibility redetermination. The bill also prohibits states from applying asset tests when determining eligibility of individuals.

Excludes the following groups from the MAGI, and allows states to apply income disregards and asset tests to individuals in these groups:

- Individuals eligible for Medicaid through another program, such as SSI, Child Welfare, or another program that establishes Medicaid eligibility external to the Medicaid agency;
- Individuals age 65 and older;
- Individuals who are eligible for Medicaid because of blindness or a disability;
- Individuals eligible for Medicaid as "Medically Needy"; and
- Individuals eligible for Medicare Cost Sharing (Medicare Savings Plan).

Also excluded from MAGI and the asset removal provisions are determinations of eligibility for Long-term Care, and State determinations of eligibility for Medicare premium and cost-sharing subsidies under section 1860D–1 of the Social Security Act. The State may also rely on the findings of an "express lane agency" to determine eligibility for Medicaid.

Section 2003 – Requirement to Offer Premium Assistance for Employer-Sponsored Insurance

Section 2003 (as amended by Section 10203) amends Section 1906A to permit states to offer premium assistance and wrap-around benefits to all Medicaid beneficiaries, when it is cost-effective to do so[1]. Individuals are not required to enroll in employer-sponsored plans and can disenroll from coverage at any time. Section 1906A requires states to pay premium and cost sharing amounts that exceed the limits placed on premiums and nominal cost-sharing in Medicaid.

[1] Sec. 2003 requires states to offer premium assistance; Sec. 10203 strikes the language creating the requirement and retains the policy as a state option.

Section 2004 – Medicaid Coverage for Former Foster Care Children

Section 2004 (as amended by Section 10201) establishes a new mandatory categorical eligibility group, effective January 1, 2014. This group is comprised of individuals who are under age 26; who are not eligible for Medicaid through another mandatory eligibility group (except for the 133% expansion); and who were in foster care and enrolled in Medicaid on the day that they turned 18 (or the day that the individual turned whatever age individuals age out of foster care in the state). This group is exempt from mandatory enrollment in Medicaid Benchmark Benefits packages. Furthermore, if an individual simultaneously qualifies for this group and for the 133% expansion group, the state must enroll them into this categorical group.

Section 2005 Payments to Territories

Increases the spending caps for the territories by 30 percent and the applicable FMAP by five percentage points – to 55 percent – beginning on January 1, 2011 and for each fiscal year thereafter. Beginning in 2014, payments made to the territories with respect to amounts expended for medical assistance for newly eligible individuals would not count against the spending caps.

Section 2006 Special Adjustment for FMAP Determination for Certain States Recovering from a Major Disaster

Reduces projected decreases in Medicaid funding for States that have experienced major, statewide disasters.

Section 2007 Medicaid Improvement Fund Rescission

Rescinds $700 million available from 2014 – 2018 for "Medicaid Improvement" – including contractor oversight and demonstration project evaluation

Subtitle B- Enhanced Support for the Children's Health Insurance Program

Section 2101 Additional Federal Financial Participation for CHIP

Extends the current reauthorization period of CHIP for two years, through 9/30/15.

States would be required to maintain income eligibility levels for CHIP through September 30, 2019. From fiscal year 2016 to 2019, States would receive a 23 percentage point increase in the CHIP match rate, subject to a cap of 100 percent.

After October 1, 2013, the enrollment bonus payments for children ends.

Children who can't enroll in the Children's Health Insurance Program (CHIP) because allotments are capped are deemed ineligible for CHIP and, therefore, eligible for tax credits in the exchanges.

Precludes transitioning coverage from CHIP to the Exchange without Secretarial certification.

Section 2102 Technical Corrections

Makes a number of corrections to the CHIPRA legislation passed on 2/4/2009. The changes are retroactively effective upon the date of CHIPRA enactment. Changes include:

- Adjustments to CHIP allotments (for FY10) for states with previously approved Medicaid expansions effective January 1, 2006, that provide coverage for children from birth through age 5 in families up to 200 percent of the poverty line;
- A technical correction to lawfully residing immigrants in section 605 of CHIPRA;
- Makes adjustments to the Current Population Survey estimates used to identify "high performing" states under CHIPRA; and
- Ensures that alternative premiums/cost sharing provisions in Medicaid do not supersede premium and cost-sharing protections for Native Americans.

Subtitle C - Medicaid and CHIP Enrollment Simplification

Section 2201 – Enrollment Simplification and Coordination with State Health Insurance Exchanges

Beginning January 1, 2014, as a condition of receiving any FFP for Medicaid, the bill requires states to:

- Establish a process to allow individuals to apply for, enroll in, and renew their enrollment in Medicaid through a website. The website must be linked to the exchange and CHIP. The website must also allow individuals who are eligible for Medicaid and for tax credits in the exchange to compare the available benefits, premiums and cost sharing for each private plan with Medicaid;
- Accept Medicaid and CHIP eligibility determinations made by the exchange, and enroll individuals determined eligible by the exchange without any further determination;
- Determine eligibility and enroll individuals in a health plan through the exchange (without any additional application), and establish eligibility for premium assistance credits, for individuals who apply for Medicaid or CHIP and are determined ineligible. States must also ensure that these individuals receive information about cost-sharing credits;
- Ensure that the exchange, Medicaid and CHIP utilize a secure electronic interface sufficient to allow for a determination of an individual's eligibility and enrollment for any of those programs;
- Coordinate medical assistance provided through CHIP or Medicaid with any coverage provided through the exchange, when individuals are enrolled in Medicaid or CHIP and a qualified exchange plan; and
- Conducting outreach and enrollment efforts to venerable populations, including children, unaccompanied homeless youth, children and youth with special health care needs, pregnant women, racial and ethnic minorities, rural populations, victims of abuse or trauma, individuals with mental health or substance-related disorders, and individuals with HIV/AIDS.

The bill allows State Medicaid and CHIP agencies to enter into an agreement with an Exchange to determine whether a State resident is eligible for premium assistance tax credits so long as the agreement meets such conditions and requirements as the Secretary of the Treasury may prescribe to reduce administrative costs and the likelihood of eligibility errors and disruptions in coverage.

The bill requires State Medicaid agency and State CHIP to participate in and comply with the requirements for streamlined enrollment procedures between Medicaid, CHIP and the Exchange.

Finally, this section clarifies that none of the changes to the eligibility and enrollment procedures would alter state requirements to assess eligibility for HCBS.

Section 2202 – Permitting Hospitals to Make Presumptive Eligibility Determinations for All Medicaid Eligible Populations

Beginning January 1, 2014, states may permit any hospital participating in Medicaid to determine presumptive eligibility for all Medicaid categories (not just the current groups that allow presumptive eligibility). The presumptive eligibility determinations made by hospitals will have the same requirements that apply to current presumptive eligibility processes. Payments made for medical assistance during the presumptive period are not subject to review for improper payments based upon state eligibility determinations.

Subtitle D – Improvements to Medicaid Services

Section 2301 – Coverage for Freestanding Birth Center Services

The bill establishes care provided in free-standing birth centers as a mandatory Medicaid service. Free-standing birth centers are defined as health centers that are not hospitals, where childbirth is planned to occur away from the pregnant woman's residence, that are licensed or otherwise approved by the State to provide prenatal labor and delivery or postpartum care and other ambulatory services that are included in the plan, and that comply with any state-defined requirements relating to the health and safety of individuals.

Section 2302 – Concurrent Care for Children in Hospice

In Medicaid and CHIP, if a child elects to receive hospice care, the bill allows continued payment for other Medicaid services, including those that treat the terminal condition.

Section 2303 – State Eligibility Option for Family Planning Services

Creates a new optional eligibility group with a limited service package. Individuals eligible for this group are people who are not pregnant and who have incomes below the highest eligibility level for pregnant women in Medicaid or CHIP; the state also has the option to transition individuals from a family planning waiver to the new optional eligibility group. The service package is limited to family planning services and supplies described in section 1905(a)(4)(C) including medical diagnosis and treatment services that are provided as part of family planning services. States can allow presumptive eligibility for individuals through this group. If a state provides presumptive eligibility,

the service package is limited to family planning services and supplies described in section 1905(a)(4)(C) with the option to provide (or not to provide) medical diagnosis and treatment services that are provided as part of family planning services.

Section 2304 – Clarification of Definition of Medical Assistance

Amends the definition of "medical assistance" in Section 1905(a) of the Social Security Act to include both the payment of part or all of the cost of care and services or the care and services themselves, or both.

Subtitle E – New Options for States to Provide Long-Term Services and Supports

Section 2401 – Community First Choice Option

Creates an additional mechanism to provide HCBS through the state plan. States could provide HCBS to individuals eligible under the state plan whose income does not exceed 150 percent of the poverty line, or, for individuals who meet nursing home level of care requirements, up to the income level applicable for an individual who has been determined to require an institutional level of care to be eligible for nursing facility services under the State plan. States that elect to include the community first choice option would be eligible for a 6% FMAP increase for services provided under the option.

A state that elects to include this option must: establish and collaborate with a development and implementation council; provide these services statewide, in a consumer-directed fashion, and deliver services in the most-integrated setting based upon the individual's needs; maintain or exceed the prior year's level of expenditure for services to people with disabilities and the elderly through 1905(a), 1915, 1115 (or another mechanism) during the first full year of implementation; establish a statewide quality assurance system; and collect and report information that HHS deems necessary to provide oversight and evaluation of the services provided.

Delay in Community First Choice Option. *The Reconciliation Bill Postpones from October 1, 2010 until October 1, 2011 the effective date of the option established for State Medicaid programs to cover attendant care services and supports for individuals who require an institutional level of care*

Section 2402 – Removal of Barriers to Providing Home and Community-Based Services

The legislation requires HHS to promulgate regulations that support flexible, consumer-oriented HCBS services funded by both Medicaid and other sources.

This section also modifies the 1915(i) benefits package that was created by the Deficit Reduction Act. Major changes include:

- The option to simultaneously enroll individuals in 1915(i) and 1915(c)/1115/1915(d)/1915(e) HCBS services;
- Increasing the income limit to 300% of SSI for individuals concurrently enrolled in a 1915(c) waiver;

- Removing the option to limit enrollment in the option;
- Removing the option to waive statewideness;
- Allowing states to waive comparability;
- Removing the option to limit the time period that individuals remain in the benefit after a change to the needs-based criteria. Individuals who lose eligibility due to a change in the criteria would remain eligible for services until they no longer meet the needs based criteria that they were initially admitted though;
- Creating a new optional eligibility group where individuals become Medicaid eligible through the 1915(i) waiver (similar to the special income group for 1915(c) waivers);
- Allowing states to target specific populations and to change the amount, duration and scope of services for different populations. If a state chooses to adopt this provision, it will be effective for five years, with ongoing five-year renewal periods; and
- Adding the "other" services to the allowable benefits packages. States can use "other" to craft flexible benefits packages similar to the option in 1915(c) waivers.

Section 2403 - Money Follows the Person Rebalancing Demonstration

Amends the Deficit Reduction Act of 2005 to: (1) extend through FY2016 the Money Follows the Person Rebalancing Demonstration; and (2) reduce the residential stay requirement from 6 months to 90 days.

Section 2404 – Protection for Recipients of Home- and Community-Based Services Against Spousal Impoverishment

For a five year period beginning on January 1, 2014, states are required to apply the spousal impoverishment rules in Section 1924 of the Social Security Act to individuals in institutions and to individuals in home and community based services provided through sections 1915(c), 1915(d), 1915(i) or 1115 of the social security act. Currently, states are required to apply the spousal impoverishment rules to individuals in institutions and have the option to apply spousal impoverishment rules to individuals in home and community based services. At the end of the five year period, the requirement ends and states will have the option to apply spousal impoverishment to home and community based services.

Subtitle F – Medicaid Prescription Drug Coverage

Section 2501 - Prescription drug rebates

Would apply to managed care organizations. The rebate amounts would be increased with the minimum rebate percentage for single source and innovator multiple source drugs going from 15.1% to 23.1% and from 11% to 13% for generic drugs. The rebate for clotting factors and outpatient drugs approved by the Food and Drug Administration exclusively for pediatric indications would increase to 17.1 percent.

Drug rebates for new formulations of existing drugs. *Under the Reconciliation Act, for purposes of applying the additional rebate, narrows the definition of a new formulation of a drug to a line extension of a single source or innovator multiple source drug that is an oral solid dosage form of the drug.*

Sec 2502 - Elimination of Exclusion of Coverage of Certain Drugs

Eliminates the exclusion from Medicaid coverage of (thereby extending coverage to) certain drugs used to promote smoking cessation, as well as barbiturates and benzodiazepines.

Sec 2503 -Providing Adequate Pharmacy Reimbursement

This section changes the federal upper limit to no less than 175% of the weighted average (determined on the basis of utilization) of the most recently reported monthly average manufactured price.

Subtitle G – Medicaid Disproportionate Share Hospital Payments

Section 2551 Disproportionate Share Hospital Payments

If you are a low DSH state and you have not spent more than 99.90 percent of the DSH allotment for your state on average for the period of fiscal years 2004-2008, as of 9/30/09 your applicable percentage is 25. If you are a low DSH state and you have spent more than 99.90 percent of your DSH allotments on average for the period of fiscal years 2004-2008 as of 9/30/09 your applicable percentage will be 17.5. If you are not a low DSH state and you have not spent more than 99.90 percent of the DSH allotments on average for the period of fiscal years 2004-2008 as of 9/30/09 your percentage will be 50. If you are not a low DSH state and you have spent more than 99.90 percent of the DSH allotments on average for the period of fiscal years 2004-2008 as of 9/30/09 your percentage is 35.

Thereafter the state's DSH allotment would be reduced using a calculation based on further reduction in the rate of uninsured your percentage will differ whether you are a low or high DSH state and whether you have spent more or less than 99.90 percent of your DSH allotment.

If you are a low DSH state and you have not spent more than 99.90 percent of your DSH allotment you will receive a 27.5 percent reduction. If you are a low DSH state and you have spent more than 99.90 percent of your DSH allotment you will receive a 20 percent reduction. If you are not a low DSH state and you have not spent more than 99.90 percent of your DSH allotment you will get a 55 percent reduction and if you are not a low DSH state and you have spent more than 99.90 percent of your DSH allotment you will get a 40 percent reduction.

A state's DSH allotment would not decrease by more than 50% of the allotment in 2012.

Any portion of the state's DSH allotment that is currently being used to expand eligibility through a section 1115 waiver is exempt from the reductions.

Gives Hawaii special rules for their Medicaid Disproportionate Share Hospital (DSH) allotment.

Disproportionate share hospital payments. The Reconciliation Act lowers the reduction in federal Medicaid DSH payments from $18.1 billion to $14.1 billion and advances the reductions to begin in fiscal year 2014. Directs the Secretary to develop a methodology for reducing federal DSH allotments to all states in order to achieve the mandated reductions. Extends through FY 2013 the federal DSH allotment for a state that has a $0 allotment after FY 2011.

Subtitle H – Improved Coordination for Dual Eligible Beneficiaries

Section 2601 - 5 year period for Demonstration projects.

This section clarifies the Medicaid demonstration authority for coordinating care for dual eligibles may be as long as five years.

Section 2602 - Providing Federal Coverage and Payment Coordination for Dual Eligible Beneficiaries

Establishes a new office in CMS, the Federal Coordinated Health Care Office for Dual Eligible Beneficiaries. The office would be tasked with improving programmatic and regulatory coordination between Medicare and Medicaid, improving access to services, and increasing dual eligible enrollee satisfaction.

Subtitle I – Improving the Quality of Medicaid for Patients and Providers

Section 2701 Adult Health Quality Measures

The Secretary would create procedures to identify health care quality measurements for Medicaid-eligible adults similar to the procedures already underway for children. The Secretary would also establish procedures for and provide grants to states to collect and voluntarily report health care quality data for Medicaid-eligible adults. The Secretary in consultation with states, would be required to identify specific preventable health care acquired conditions and would prohibit payments for services related to such conditions.

Section 2702 - Payment Adjustment for Health Care-Acquired Conditions

Effective 7/1/11 would prohibit payments to states for Medicaid services related to health care acquired conditions.

Section 2703 – State Option to Provide Health Homes for Enrollees with Chronic Conditions

Establishes a Medicaid state plan option, beginning January 1, 2011, for individuals with chronic conditions to designate a "health home" to coordinate the delivery of their health care. Eligible individuals are people eligible for Medicaid who either have at least 2 chronic conditions; have 1 chronic condition and are at risk for having a second chronic condition; or who have a serious and persistent mental health condition. Chronic conditions will be defined by HHS, but must include: A mental health condition,

substance use disorder, asthma, diabetes, heart disease, or overweight/obesity (as evidenced by having a Body Mass Index over 25).

The health home can be a designated provider, a team of health care professionals operating with such a provider, or a health team, provided that the health home meets standards established by HHS. These could include: physician, clinical practice or clinical group practice, rural clinic, community health center, community mental health center, home health agency, or any other entity or provider (including pediatricians, gynecologists, and obstetricians) that meets state and federal requirements to act as a health home.

Services provided by the health home include: comprehensive care management; care coordination and health promotion; comprehensive transitional care, including appropriate follow-up, from inpatient to other settings; patient and family support (including authorized representatives); referral to community and social support services, if relevant; and use of health information technology to link services, as feasible and appropriate.

For the first 8 quarters that a state establishes this option, it will receive 90% FMAP for those services. After the first 8 quarters, services will be paid at the regular state FMAP. The section establishes planning grants, matched at the state's regular FMAP, to assist states develop an amendment to implement this option. Additionally, HHS is directed to evaluate this program through an independent entity.

Section 2704 - Demonstration Project to Evaluate Integrated Care Around a Hospitalization

Directs the Secretary to establish a demonstration project to evaluate the use of bundled payments for the provision of integrated care for a Medicaid beneficiary: (1) with respect to an episode of care that includes a hospitalization; and (2) for concurrent physicians services provided during a hospitalization.

Section 2705 - Medicaid Global Payment System Demonstration Project

Establishes a demonstration project, in coordination with the CMS Innovation Center, in up to five States that would allow participating States to adjust their current payment structure for safety net hospitals from a fee-for-service model to a global capitated payment structure.

Section 2706 - Pediatric Accountable Care Organization Demonstration Project

Establishes a demonstration project that allows qualified pediatric providers to be recognized and receive payments as Accountable Care Organizations (ACO) under Medicaid. The pediatric ACO would be required to meet certain performance guidelines. Pediatric ACOs that met these guidelines and provided services at a lower cost would share in those savings.

Section 2707 - Medicaid Emergency Psychiatric Demonstration Project

Requires the Secretary of HHS to establish a three-year Medicaid demonstration project in up to eight States. Participating States would be required to reimburse certain institutions for mental disease (IMDs) for services provided to Medicaid beneficiaries between the ages of 21 and 65 who are in need of medical assistance to stabilize an emergency psychiatric condition.

Subtitle K – Protections for American Indians and Alaska Natives

Section 2901 – Special Rules Relating to Indians

Requires no cost sharing in the state exchanges for Indians with income at or below 300 % of poverty and health programs operated by the Indian Health Service, Indian tribes, tribal organizations, Urban Indian organizations shall be the payer of last resort for services provided to eligible individuals.

TITLE IV—PREVENTION OF CHRONIC DISEASE AND IMPROVING PUBLIC HEALTH

Subtitle B—Increasing Access to Clinical Preventive Services

Section 4101 - School-based health centers. (as modified by Sec. 10402)

Requires the Secretary to establish a program to award grants to eligible entities to support the operation of school-based health centers.

Section 4102 - Oral healthcare prevention activities.

Requires the Secretary, acting through the Director of CDC, to carry out oral health activities, including: (1) establishing a national public education campaign that is focused on oral health care prevention and education; (2) awarding demonstration grants for research-based dental caries disease management activities; (3) awarding grants for the development of school-based dental sealant programs; and (4) entering into cooperative agreements with state, territorial, and Indian tribes or tribal organizations for oral health data collection and interpretation, a delivery system for oral health, and science-based programs to improve oral health.

Requires the Secretary to: (1) update and improve the Pregnancy Risk Assessment Monitoring System as it relates to oral health care; (2) develop oral health care components for inclusion in the National Health and Nutrition Examination Survey; and (3) ensure that the Medical Expenditures Panel Survey by AHRQ includes the verification of dental utilization, expenditure, and coverage findings through conduct of a look-back analysis.

Section 4106 – Improving Access to Preventive Services for Eligible Adults in Medicaid

Beginning January 1, 2013, the state option for diagnostic, screening, preventive and rehabilitation services are expanded to include any clinical preventive services that are assigned a grade of A or B by the United States Preventive Services Task Force and adult vaccines recommended by the Advisory Committee on Immunization practices, and the administration of those adult vaccines. States that elect to cover these services, and that do not require cost-sharing for the services, will receive a 1% FMAP increase for preventive services and for the tobacco cessation services described in Sec. 4107.

Section 4107 – Coverage of Comprehensive Tobacco Cessation Services for Pregnant Women in Medicaid

Beginning October 1, 2010, States are required to cover comprehensive tobacco cessation services for pregnant women in Medicaid. Comprehensive tobacco cessation services are defined as diagnostic, therapy, and counseling services and pharmacotherapy (including the coverage of prescription and nonprescription tobacco cessation agents approved by the Food and Drug Administration) for cessation of tobacco use by pregnant women. The services are limited to ones recommended for pregnant women in "Treating Tobacco Use and Dependence: 2008 Update: A Clinical Practice Guideline', published by the Public Health Service (or to any services included in updated versions of that publication). States would not be permitted to require cost-sharing for these services.

Section 4108 - Incentives for Prevention of Chronic Diseases in Medicaid.

Requires the Secretary to award grants to states to carry out initiatives to provide incentives to Medicaid beneficiaries who participate in programs to lower health risk and demonstrate changes in health risk and outcomes.

TITLE VI—TRANSPARENCY AND PROGRAM INTEGRITY

Subtitle E—Medicare, Medicaid, and CHIP Program Integrity Provisions

Section 6401 - Provider screening and other enrollment requirements under Medicare, Medicaid, and CHIP (as modified by Sec. 10603)

Amends Medicare to require the Secretary to: (1) establish procedures for screening providers and suppliers participating in Medicare, Medicaid, and CHIP; and (2) determine the level of screening according to the risk of fraud, waste, and abuse with respect to each category of provider or supplier.

Requires providers and suppliers applying for enrollment or revalidation of enrollment in Medicare, Medicaid, or CHIP to disclose current or previous affiliations with any provider or supplier that: (1) has uncollected debt; (2) has had its payments suspended; (3) has been excluded from participating in a federal health care program; or (4) has had billing privileges revoked. Authorizes the Secretary to deny enrollment in a program if these affiliations pose an undue risk to it.

Requires providers and suppliers to establish a compliance program containing specified core elements.

Directs the CMS Administrator to establish a process for making available to each state agency with responsibility for administering a state Medicaid plan or a child health plan under SSA title XXI the identity of any provider or supplier under Medicare or CHIP who is terminated.

Section 6402 - Enhanced Medicare and Medicaid program integrity provisions.

Requires CMS to include in the integrated data repository claims and payment data from Medicare, Medicaid, CHIP, and health-related programs administered by the Departments of Veterans Affairs (VA) and DOD, the Social Security Administration, and IHS.

Directs the Secretary to enter into data-sharing agreements with the Commissioner of Social Security, the VA and DOD Secretaries, and the IHS Director to help identity fraud, waste, and abuse.

Requires that overpayments be reported and returned within 60 days from the date the overpayment was identified or by the date a corresponding cost report was due, whichever is later.

Directs the Secretary to issue a regulation requiring all Medicare, Medicaid, and CHIP providers to include their National Provider Identifier on enrollment applications.

Authorizes the Secretary to withhold the federal matching payment to states for medical assistance expenditures whenever a state does not report enrollee encounter data in a timely manner to the state's Medicaid Management Information System.

Authorizes the Secretary to exclude providers and suppliers participation in any federal health care program for providing false information on any application to enroll or participate.

Subjects to civil monetary penalties excluded individuals who: (1) order or prescribe an item or service; (2) make false statements on applications or contracts to participate in a federal health care program; or (3) know of an overpayment and do not return it. Subjects the latter offense to civil monetary penalties of up to $50,000 or triple the total amount of the claim involved.

Authorizes the Secretary to issue subpoenas and require the attendance and testimony of witnesses and the production of any other evidence that relates to matters under investigation or in question.

Requires the Secretary take into account the volume of billing for a durable medical equipment (DME) supplier or home health agency when determining the size of the

supplier's and agency's surety bond. Authorizes the Secretary to require other providers and suppliers to post a surety bond if the Secretary considers them to be at risk.

Authorizes the Secretary to suspend payments to a provider or supplier pending a fraud investigation.

Appropriates an additional $10 million, adjusted for inflation, to the Health Care Fraud and Abuse Control each of FY2011-FY2020. Applies inflation adjustments as well to Medicare Integrity Program funding.

Requires the Medicaid Integrity Program and Program contractors to provide the Secretary and the HHS Office of Inspector General with performance statistics, including the number and amount of overpayments recovered, the number of fraud referrals, and the return on investment for such activities.

Section 6403 - Elimination of duplication between the Healthcare Integrity and Protection Data Bank and the National Practitioner Data Bank.

Requires the Secretary to furnish the National Practitioner Data Bank (NPDB) with all information reported to the national health care fraud and abuse data collection program on certain final adverse actions taken against health care providers, suppliers, and practitioners.

Requires the Secretary to establish a process to terminate the Healthcare Integrity and Protection Databank (HIPDB) and ensure that the information formerly collected in it is transferred to the NPDB.

Subtitle F—Additional Medicaid Program Integrity Provisions

Section 6501 - Termination of provider participation under Medicaid if terminated under Medicare or other State plan.

Amends Medicaid to require states to terminate individuals or entities (providers) from their Medicaid programs if they were terminated from Medicare or another state's Medicaid program.

Section 6502 - Medicaid exclusion from participation relating to certain ownership,control, and management affiliations

Requires Medicaid agencies to exclude individuals or entities from participating in Medicaid for a specified period of time if the entity or individual owns, controls, or manages an entity that:

1. Has failed to repay overpayments during a specified period;
2. Is suspended, excluded, or terminated from participation in any Medicaid program; or
3. Is affiliated with an individual or entity that has been suspended, excluded, or terminated from Medicaid participation.

Section 6503 - Billing agents, clearinghouses, or other alternate payees required to register under Medicaid

Requires state Medicaid plans to require any billing agents, clearinghouses, or other alternate payees that submit claims on behalf of health care providers to register with the state and the Secretary.

Section 6504 - Requirement to report expanded set of data elements under MMIS to detect fraud and abuse.

Requires states to submit data elements from the state mechanized claims processing and information retrieval system (under the Medicaid Statistical Information System) that the Secretary determines necessary for program integrity, program oversight, and administration.

Requires a Medicaid managed care entity contract to provide for maintenance of sufficient patient encounter data to identify the physician who delivers services to patients (as under current law) at a frequency and level of detail to be specified by the Secretary.

Section 6505 – Prohibition on payments to institutions or entities located outside of the United States

Requires a state Medicaid plan to prohibit the state from making any payments for items or services under a Medicaid state plan or a waiver to any financial institution or entity located outside of the United States.

Section 6506 – Overpayments

Extends the period for States to repay overpayments to one year when a final determination of the amount of the overpayment has not been determined due to an ongoing judicial or administrative process. When overpayments due to fraud are pending, State repayments of the Federal portion would not be due until 30 days after the date of the final judgment.

Section 6507 - Mandatory State use of national correct coding initiative

Requires state mechanized Medicaid claims processing and information retrieval systems to incorporate methodologies compatible with Medicare's National Correct Coding Initiative.

Section 6508 - General effective date

Except as otherwise provided, the effective date for Subtitle F (Additional Medicaid Program Integrity Provisions) is January 1, 2011, with a delay if state legislation is necessary. If legislation is necessary, states must come into compliance by the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment (The bill was enacted on March 23, 2010).